FREQUENTLY ASKED QUESTIONS - II
REGARDING SERVICES FOR CHILDREN[1]
May 2014[2]

PMDDT PROCESS

Q1: When will medical benefits be available once a child has completed the PMDDT process?

A1: The effective date of the medical benefits is the date the child is enrolled in Waiver services – which is when the LOC, needs assessment and in-home service plan are completed.

Q2: Does a child need to go through the PMDDT process to get OSIPM only for Waiver services; or is it also required to receive K-Plan services?

A2: OSIPM is not required for K plan access, but the individual must be on OHP plus (Title XIX Medicaid, not Title XXI CHIP) and meet level of care (LOC) criteria. In order to receive waiver services, however, an individual needs to be receiving OSIPM benefits. For children, services available through the Waiver include Family Training and Waiver Case Management.

Q3: Can a child receive K Plan services while going through the PMDDT process in order to qualify for OSIPM?

A3: Yes, if a child meets qualifications for K Plan services, he/ she may receive K Plan services while going through the PMDDT process. To qualify for K Plan services, a child must be Medicaid eligible, meet LOC criteria, received a functional need assessment, and have an ISP developed based on identified support needs.

Q4: When a child loses SSI due to the family being over income or resources, what is the process to help the child obtain medical benefits and in-home supports and services through Waiver and/or K-plan services?

[1] This FAQ addresses questions regarding CDDPs assisting children with intellectual or developmental disabilities to access services through K Plan and/ or the Comprehensive Services Waiver.

[2] This FAQ builds on the FAQ document previously released in January 2014

A4: Depending on the family's situation, and the necessity of having continuity of services in place, the options for families include:

If loss of SSI is within the last 12 months of the last OSIPM determination, the child is assumed eligible for OSIPM until the end of the 12th month. At the end of the 12th month, the child's medical eligibility will need to be redetermined as followed:

a. If the child needs Waiver services, go through the PMDDT process to pursue Medicaid benefits for beyond those 12 months. Provide CMEU a copy of the child's latest SSA award letter and a completed *Authorization of Use and Disclosure Information form* (MSC 2099) authorizing release to the Social Security Administration (SSA). PMDDT can do a courtesy verification of the child's disability status with SSA. (If CMEU is unable to complete the courtesy check, or the check does not confirm meeting disability criteria, the full PMDDT process must be followed.)

b. If the child does not need Waiver services, apply directly for medical benefits. The avenues for accessing Oregon Health Plan services are described at this website: http://www.oregon.gov/oha/healthplan/Pages/apply.aspx. The application (OHP 7210) in English and other languages can also be downloaded from DHS/OHA Forms server (https://aix-xweb1p.state.or.us/es_xweb/FORMS/) to complete and fax to the OHP Processing Center at 503-373-7493.

The decision which of the above services will be pursued is based on factors such as continuity of services and whether Waiver services are desired.

Q5: What is implication of the 300% rule for children? What are barriers to applying to kids?

A5: The "300% rule" will apply to children in a very narrow set of circumstances. If the child applies for PMDDT, and is found to be ineligible due to his/her own income or resources, then the 300% rule may

apply if his/her income is above OSIPM/SSI income standard ($721 for an individual as of 1/1/14) and below 300% OSIPM/SSI income standard ($2163 for an individual as of 1/1/14). The allowable resource amount is up to $2000. Children who qualify under the 300% income level rule must have an assessed functional need, an active ISP, and receive a waiver service monthly in order to maintain Medicaid eligibility.
Please note: In the future, children who qualify under the 300% rule may carry a liability for services provided. Guidelines and procedures for this are not in place, and instructions will be distributed before any such change in policy is implemented.

Q6: Does a 17 year old who just got on OSIPM thru presumptive eligibility have to reapply when he turns 18?

A6: PMDDT **does** need to review the disability status. This is because SSA uses different medical and non-medical rules to determine disability and SSI payment for a child vs. for an adult, and PMDDT must adhere to SSA's disability determination requirements – when a youth turns 18 and has not received a disability determination by SSA. In order to continue receiving in-home services through Medicaid, the individual still needs to go through an annual medical and financial redetermination process, depending on the date of the last eligibility determination.

It is possible that a youth would go through an SSI determination at the same time as going through the PMDDT process, and receive an approval for SSI just a few months prior to the 18th birthday. In this case, the individual will **not** need to go through the PMDDT process again, as long as he/she continues to receive SSI benefits.

Q7: Is an annual redetermination required?

A7: Financial eligibility for medical benefits must be redetermined annually. CMEU will send out an annual redetermination, which includes a new application. The signed redetermination application must be returned to CMEU, along with proof of current income and resources.

ACCESSING SERVICES

Q8: Can an individual receive State Plan Personal Care and K Plan services at the same time?

A8: State Plan personal Care services are used to meet the needs of those individuals that are Medicaid eligible and have need for personal care services but do not meet Level of Care. The K Plan is available to provide enhanced services to those individuals that are Medicaid eligible and meet institutional Level of Care; however an individual may choose to receive services through any available State Plan option for which they are eligible. **Medicaid services must not be duplicated**.

If an individual receives both State Plan Personal Care and K Plan supports, any attendant care support hours identified in the Children's Needs Assessment are reduced by the hours met by State Plan Personal care and may not be in addition or duplicative of K Plan hours. The child's ISP should note that SPPC is addressing these attendant care needs.

Q9: Can the parent choose for their child to remain on a DD151 General Fund plan rather than getting presumptive medical eligibility, even if it would result in fewer hours of support under the GF guidelines?

A9: No. It is expected that other available resources will be accessed prior to relying on GF services.

Q10: Are children with medical coverage through CHIP eligible for K Plan services?

A10: Children covered through CHIP are not eligible for K Plan services. (Medical coverage through CHIP, Children's Health Insurance Program, is through Title XXI). CHIP children can access State Plan Personal Care (SPPC, previously known as PC20) services, if they have ADL support needs and meet the criteria for SPPC services. Should their needs exceed what SPPC can provide, they must go through the PMDDT process to access Waiver and K Plan services.

Eligibility for services is outlined in the table below:

MEDICAL COVERAGE/ ELIGIBLITY	POTENTIAL SERVICE ELIGIBILITY
All individuals with OHP (including CHIP)	State Plan **Medical Plan**, including **State Plan Personal Care** (SPPC)
OHP Plus/ MAGI Medicaid – Title XIX (does not include CHIP/ Title XXI) Plus meet LOC	All the above, plus **K Plan services**
OSIPM Plus meet LOC	All the above, plus **Waiver services**

Q11: If a child is on CHIP (and therefore not K Plan eligible), is it appropriate for him/ her to go through PMDDT to access K Plan services?

A11: Yes, see response to question 11 above.

Q12: For children who have OHP but not OSIPM and have chosen Community First Choice (K-Plan), if the family has specified family training needs, what needs to occur?

A12: The family can seek other sources for support for attending trainings (with the assistance from the Service Coordinator), or they can pursue OSIPM eligibility through the PMDDT process. They can access K-Plan services (if eligible) while going through the PMDDT process for OSIPM benefits.

Q13: Can you please explain the various types of medical coverage for kids?

A13: Beginning January 1, 2014, new options became available for accessing medical coverage under the Affordable Care Act (ACA). The medical coverage for all programs is the same, the service options, however, do differ. These new medical programs are often referred to as "MAGI Medicaid" because they use the federal tax Modified Adjusted Gross Income (MAGI) calculation. So basically, children in Oregon can get medical coverage in 3 ways: MAGI-Medicaid, or MAGI-CHIP, or OSIPM.

K-Plan services are available to children who qualify for MAGI-Medicaid or OSIPM, and have ADL/IADL support/service needs. K-Plan services are not available to children who qualify for MAGI-CHIP.

Q14: What forms and tools are required for the different services?

A14: Currently each program has separate requirements for the assessment and budget tool. Listed below are the current requirements.

- **Family Support (SE150-GF)**: Use the **Child Annual/Family Support Plan** form (SDS 4549) for assessment and if accessing Family Support funds, the **Family Support – Use of immediate access/direct assistance funding** form (SDS 0150) for budget authorization.
- **State Plan Personal Care (SPPC):** Use the **Medicaid Personal Care Assessment** form (SDS 531C) for assessment, **SPPC - Service Plan and Task List** form (SDS 546PC) for service authorization (for up to 20 hours).

- **In-Home Support for Children (SE151- GF)**: Use the **Child Annual/Family Support Plan** form (SDS 4549) for assessment and **the Long-Term Supports for Children – Request for funding or renewal** form (SDS 0151L) for crisis/justification plan (narratives), and the new **Services & Funding/Individual Support Plan** form (SDS 0151) for budget authorization.
- **In-Home Support for Children (SE151- K Plan)**: Use the **Child Annual/Family Support Plan** form (SDS 4549) for assessment and the new **Services & Funding/Individual Support Plan** form (SDS 0151) for budget authorization. K Plan services also require the Level of Care form and the Children's Needs Assessment (CNA) tool. The **Supplemental Assessment** form is required for certain supports, as identified in the Expenditure Guidelines.

CNA and OTHER ASSESSMENT TOOLS

Q15: Are we correct in assuming that once a person has had choice advising and they are choosing to not pursue any funded services, they don't need to have a CNA or ANA (and we document this in the plan and in progress notes)?

A15: The CNA is intended to be used specifically to identify ADL and IADL support needs for use with K Plan/Waiver services. It is not required to be used for other services – for example, case management only for Family Support (DD150). As described above, if a family chooses to use K Plan and State Plan Personal Care services at the same time, any SPPC services authorized count as meeting support needs identified via the CNA.

Q16: Can a child whose CNA indicated 0 hours of support receive Relief Care?

A16: A child who is identified in the CNA as not needing ADL support hours does not qualify for Relief Care.

Q17: Do all children need to have a CNA?

A17: The CNA is intended to be used specifically to identify ADL and IADL support needs for use with K Plan/Waiver services. It is not required to be used for other services.

SERVICES

Q18: Can a child receive DD150 supports for services/ supports not available through the waiver or K Plan?

A18: A child may not access DD150 supports and K Plan/ Waiver services at the same time.

Q19: Are camps covered as a service under K Plan? And if so, what are the requirements?

A19: Disability related or therapeutic camps may be accessed for relief care for up to 14 days in a calendar year (7 consecutive days at a time unless prior authorization by ODDS has been received) as long as the camp is a certified provider agency as determined by DD licensing unit. Services must be provided in keeping with published Expenditure Guidelines. Payment is intended for attendant care to the individual, and not for other costs (i.e., fees, registration).

Q20: What are the parameters around a child accessing a bus pass through community transportation?

A20: Community Transportation for children is considered a parental responsibility. While Community Transportation is generally not considered an available resource for children, requests can be made to the ODDS Funding Review Committee, but the rationale must explain how the service is directly related to the individual's disability related needs, and why the transportation would fall outside parental responsibility for a child without a disability.

Q21: Are iPads/ tablets/ communication devices available via the K Plan?

A21: Purchasing assistive devices is allowable if it is directly related to the child's disability, there are identified goals on the ISP where this specific assistive device will assist the individual in meeting the goal, has potential to reduce the need for human assistance, and is the most cost effective option. The Supplemental Assessment form must be used to assess the need for a device. If an individual is school-aged and technology may help

them, there should be coordination with the school, as the school can often provide these items (sometimes in the child's home). There would need to be some determination about the ability of the child to use a device. Please see the Expenditure Guidelines for further details.

Q22: When are individuals required to have medical eligibility determined through PMDDT versus the local Medicaid office?

A22: Children who are Medicaid eligible and receive SSI are processed through the local Medicaid office (DSO/DAVS/APD/AAA), unless they have an open TANF case, in which case the local TANF office case manages. Children without a case open locally have their medical eligibility done through the State Processing Center (branch 5503). Children who need a presumptive Medicaid disability determination in order to access OSIPM are processed through the CMEU/ PMDDT process.

Q23: What if a child should be determined eligible for OHP Plus or PMDDT but eligibility does not show up in eXPRS?

A23: Contact DHS Technical Assistance Unit (TAU) at DD-Eligibility.Enrollment@state.or.us; TAU staff can confirm the child's type of medical eligibility. This often occurs when CHIP eligible children, opened through branch 5503, go through PMDDT, and eXPRS may not have the updated eligibility information. Please make sure you check the eligibility in eXPRS before contacting this unit.